Child REACH Annual Report
Fiscal Year 2019

The annual report this year focuses on analyzing the data with respect to where the individual regional Child REACH programs are in meeting the goal of a statewide crisis system of care that serves individuals diagnosed with a developmental disability (DD). The data set provided reviews the status of the programs in fiscal year 2019 (FY19) and analyzes trends for fiscal year comparison in order to make conclusions about the progress of the REACH program towards meeting the aforementioned goal.

The following must be noted to the reader prior to beginning to review the current fiscal year's data: 1) the Child REACH programs have been operational since July 2015 (whereas there are numerous fiscal years' worth of data for comparison purposes in the Adult REACH programs, there are three full years of data for the Child REACH programs); 2) data for the first quarter of FY16 were not available, and incomplete data was provided by some regions for other quarters in FY16; and 3) there was a recalibration in data tracking corresponding to the definition of "mobile supports" for that resulted in over-reporting of children that were receiving this service in previous fiscal years. Specifically, through the majority of FY18 (and reflective in previous fiscal years' data) child Regions I (until FY18Q4) and II (until FY18Q3) were including cases in mobile support data that were more prevention in nature and not necessarily the function of an emergent crisis event that resulted in 3 to 15 days of crisis stabilization services as is operationally defined for "mobile supports"; these data from Region II, when under a previous program operator, may also have contained individuals that were accessing mental health as opposed REACH crisis services. In the upcoming fiscal year, formal data reporting will capture data sets on both community based "mobile supports" and community based "prevention" services, the latter of which constitutes more intermittent crisis prevention services of a non-emergent nature in comparison to the comprehensive battery of crisis intervention and stabilization that occurs via "mobile supports".

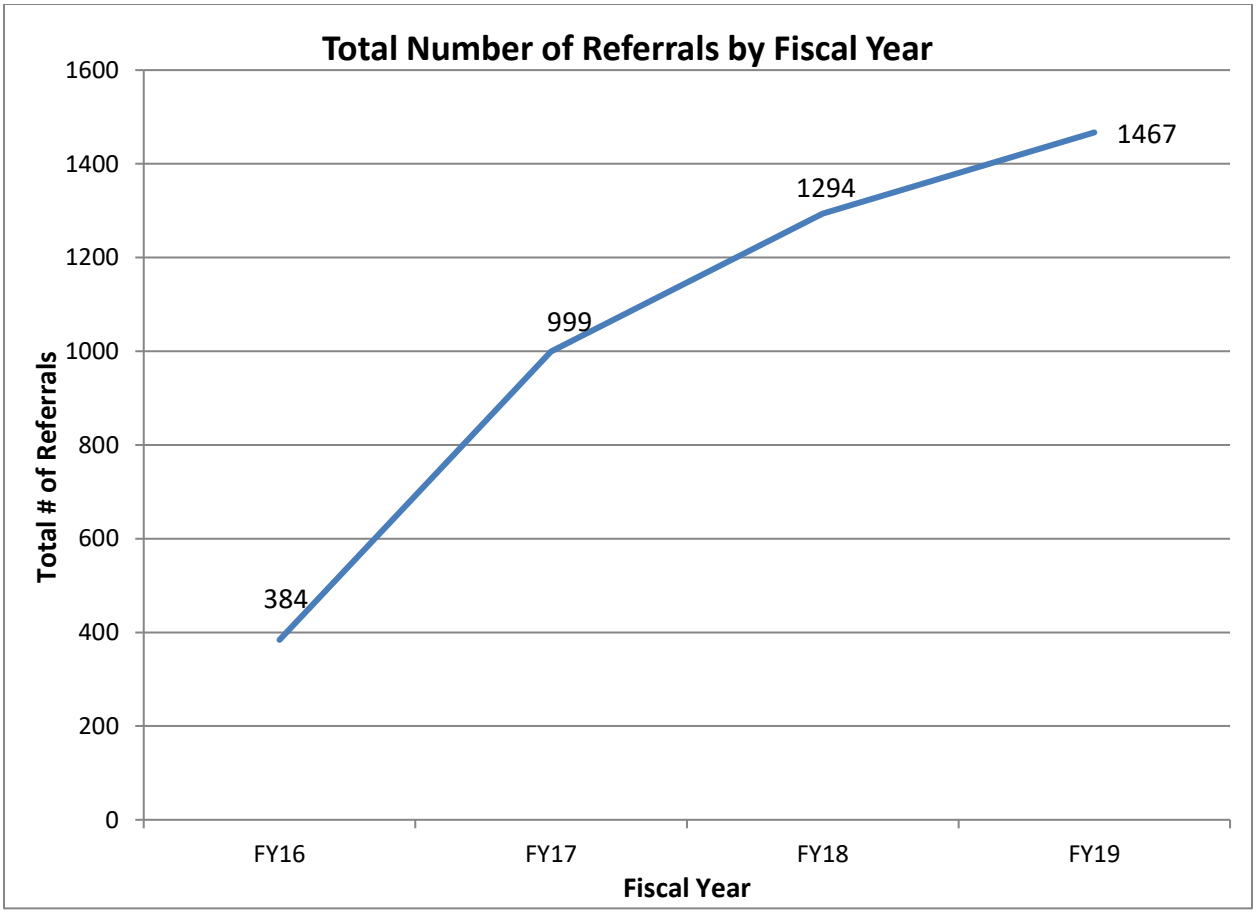
Since the Child REACH program's inception to the present date, the programs have served individuals who range in age from 3 to 17 years of age, with the majority of individuals falling within the 13 to 17 year age range. During the past several fiscal years, the Child REACH programs have seen an approximate 75% to 25% male-to-female ratio, respectively, for referrals. This ratio is congruent with the prevalence of mental health conditions and behavioral disorders across genders in the general population. As with the two previous fiscal years, the data collection for FY19 is inclusive of individuals who identify as transgender; parallel to FY, the data indicate that the programs served a small handful of transgender youth, with this population accounting for less than 1% of those served through the Child REACH programs.

The previous year's annual report (and likewise previous quarterly reports) has provided information on how many individuals supported have an intellectual disability (ID). Since its inception, the REACH Child programs have served primarily individuals without an ID diagnosis, which is in contrast to the general trend of the individuals served by the REACH Adult programs. The FY19 data indicates that approximately 72% of children served had a developmental disability diagnosis without ID (67% in FY18), approximately 11% had a dual ID/DD diagnosis (16% in FY18), and approximately 12% had a sole ID diagnosis (13% in FY18); approximately 5% of referrals did not have a qualifying diagnosis, or the diagnosis was not established at the time of the referral. These percentages are overall consistent across each of the regions over the course of the fiscal year.

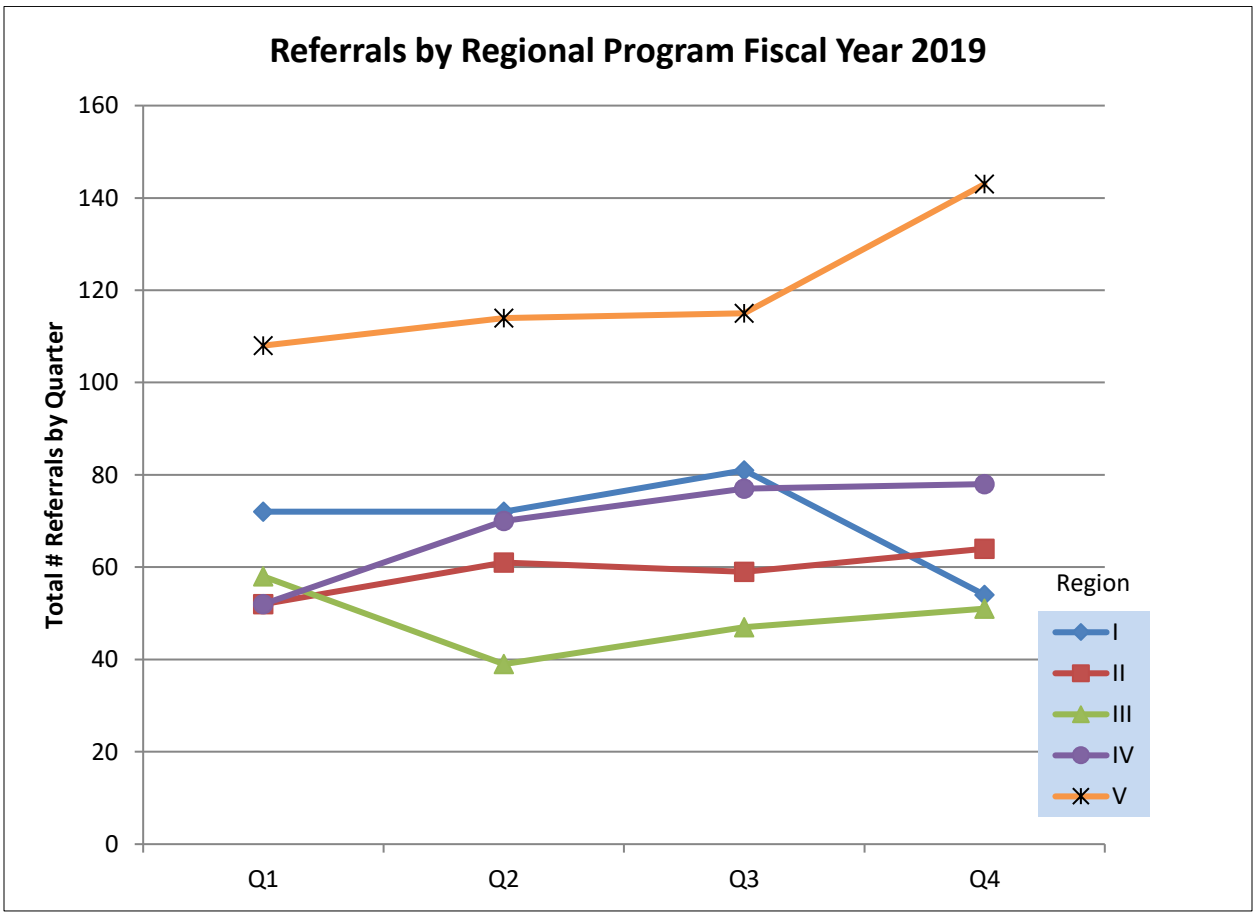
Referral Information

As previously noted, there are now three full fiscal years of data from which to draw from for analysis and comparison purposes. Data regarding referrals were absent or partial for some regions during the first quarter of FY16, which is to be expected as any new, large-scale program launches and fine tunes data collection processes and procedures during its infancy. As such, the most useful comparisons in the referral activity data sets are from FY17 onward.

As can be clearly observed in the graph below, there remains an overall ascending trend for the total number of referrals to the Child REACH program. With that noted, the overall percentage increase in referrals from FY17 to FY18 (a 30% increase) and FY18 to FY19 (a 13% increase) may be suggestive that referrals to the program will begin to level out in coming fiscal years. The charts that follow represent both crisis and non-crisis referrals combined. It is important to note that throughout the history of REACH, not every referral has resulted in ongoing service delivery; this is based upon the fact that not every family, provider, or individual will follow through with seeking services when referred in a non-crisis situation, that some families access REACH for a one time crisis and then choose not to fully engage the program's services, and that at times a referral is made to the program for an individual that is not eligible for REACH (e.g. does not carry a developmental disability diagnosis).



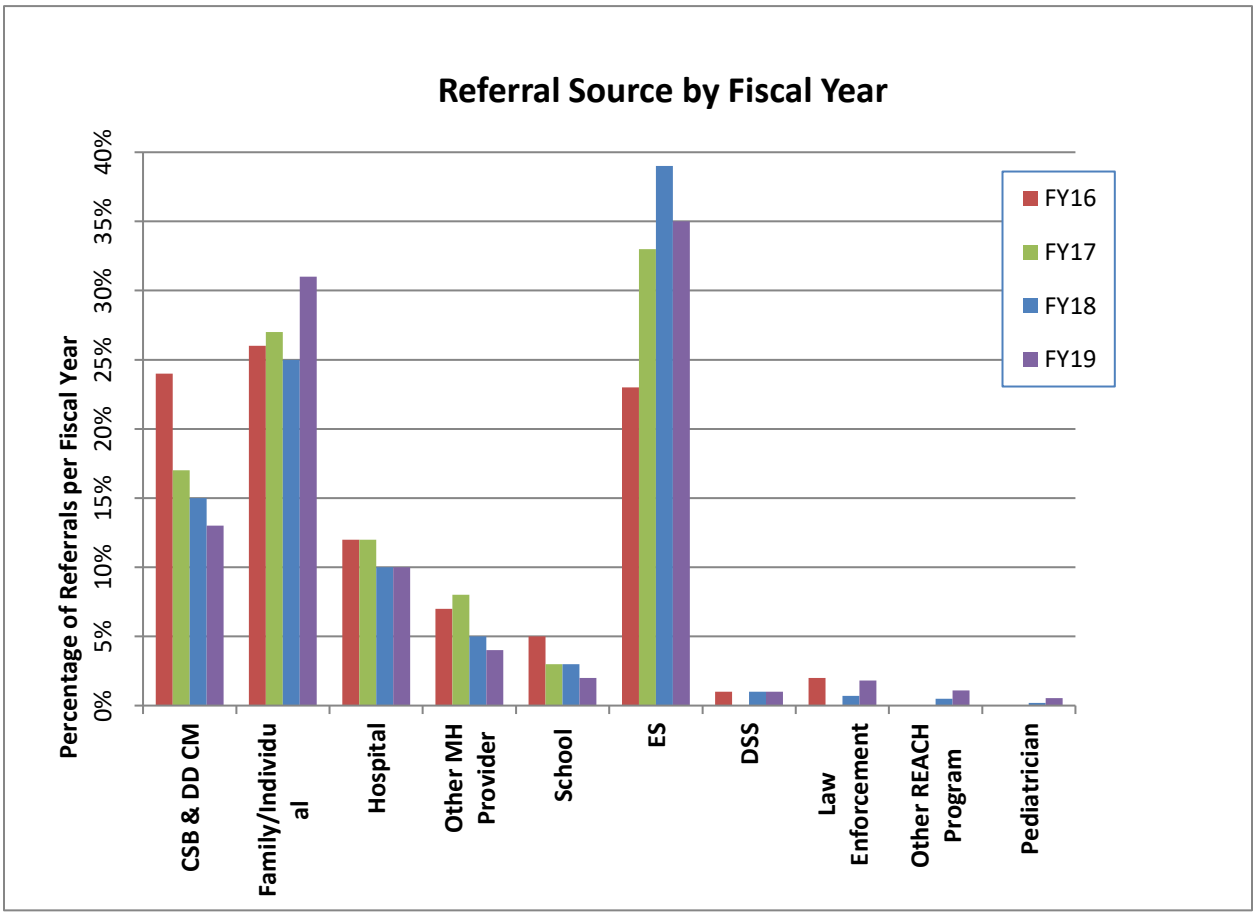
The graph below outlines the number of referrals received in each quarter by program. There is clear differentiation in the number of referrals which Region V receives in comparison to the other regions of the Commonwealth, with an overall ascending trend for this program from Q1 to Q4. It is hypothesized that the reasons for this differentiation in referrals for Region V are multifaceted in nature, and that a primary contributing variable is the population density paired with the plethora of military installations in the eastern region of the Commonwealth and transient nature of that particular population. There was general stability in referrals for Regions I, II, and III, with the exception being a decrease in Q4 for referrals for Region I. Referrals to Region IV demonstrated a general increasing trend over the course of the fiscal year, with a leveling out between Q3 and Q4.



Referral Source

One of the goals of the program is for the REACH staff to be notified, preferably by the family or provider, prior to the individual being in crisis. If the individual is in crisis, notification occurs by the same groups, or if necessary, by emergency services. This allows the Child REACH staff to be part of the discussion of where to

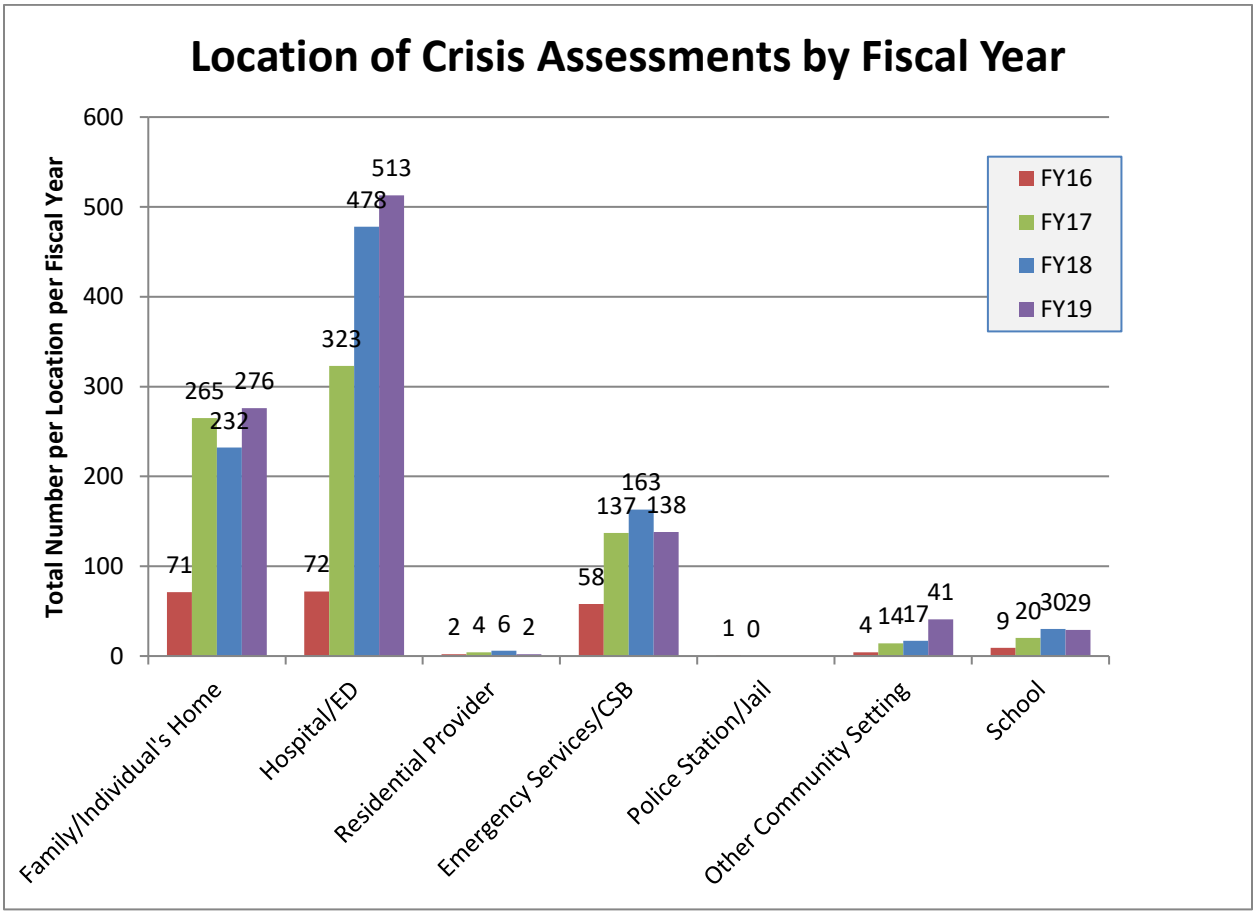
best serve the individual given the presenting issues and to possibly divert a hospitalization via mobile supports. In analysis of the data presented in the bar graph that follows, a few areas are noteworthy for consideration: 1) it is suspected that the decrease in referrals from case managers at CSBs across fiscal years is most likely due to many children who are receiving case management through a CSB already being referred in previous years and are already known to REACH; and 2) the decrease from FY18 to FY19 in referrals by emergency services to REACH and associated increase in referrals by families may be suggestive of REACH's ongoing outreach and training efforts having an impact on increasing knowledge of the program's services to families such that referrals are made prior to involvement with emergency services. As noted in previous reports, it was mandated in FY16 that emergency services contact REACH if they prescreen an individual for hospitalization who has (or is suspected of having) a developmental disability, which may be reflective of the continued overall elevated percentages of referrals from ES.



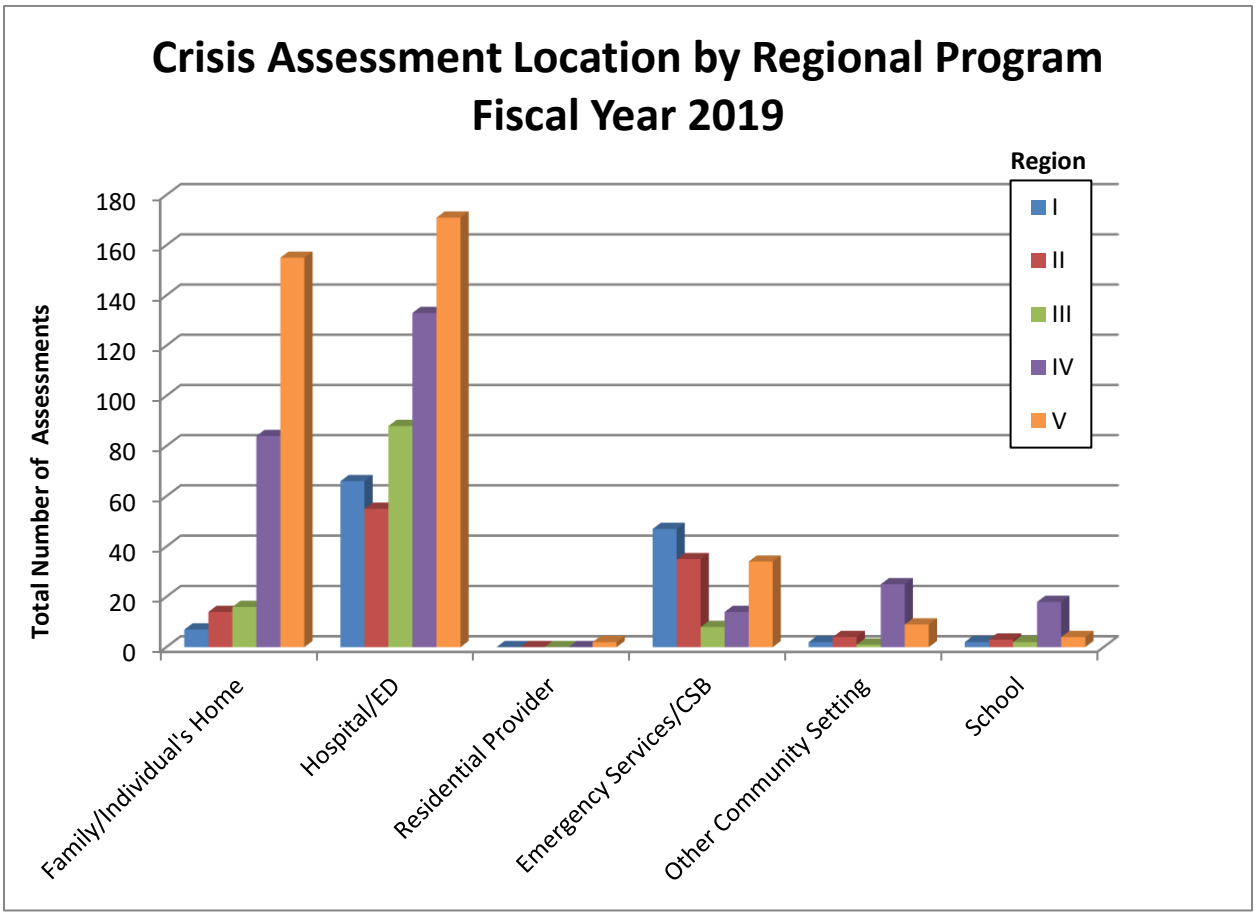
Crisis Referrals, Assessment, Presenting Problems

For every referral noted to be a crisis, a staff member responds in-person to help support the individual and complete a crisis assessment. As noted earlier in this report, the goal is to be notified as soon as possible so that REACH staff can complete an assessment and aid in a plan to help support the individual and limit hospitalizations. The charts below indicate an increase in the number of crisis assessments from FY18 to FY19

(926 in FY18 compared to 999 in FY19). The largest number of crisis assessments was completed at hospitals (both public and private). Contacting REACH, preferably prior to the child being taken to the hospital or to the CSB, provides REACH with the ability to deescalate the crisis in the setting in which it originated and to be involved in ongoing preventative crisis treatment planning for the child.



There are variations in the location of crisis assessment by regional program as shown in the chart on the next page. The reason for these variations are a function of regional differences related to other support services that are available in the community, paired with crisis assessment centers being located at many hospital locations throughout the Commonwealth.

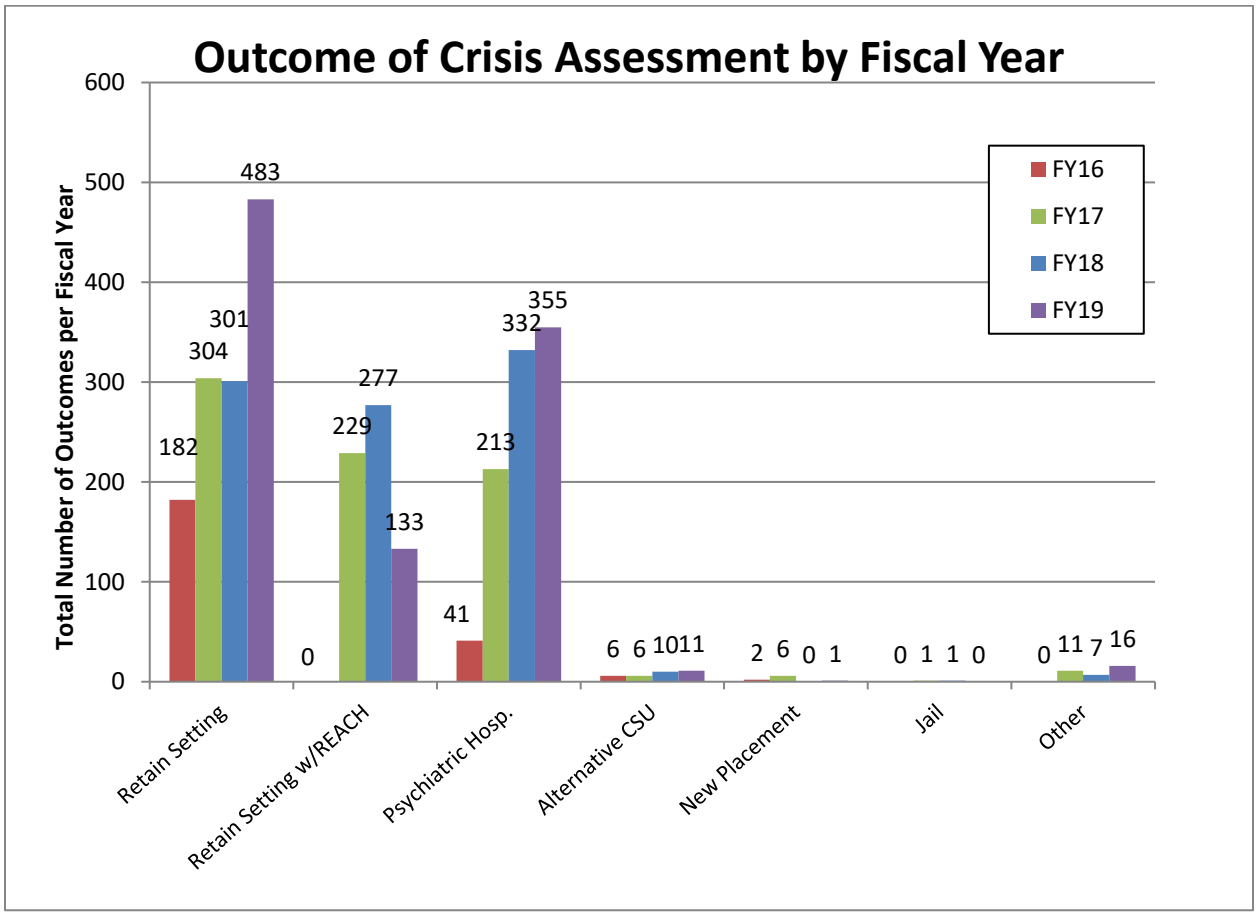


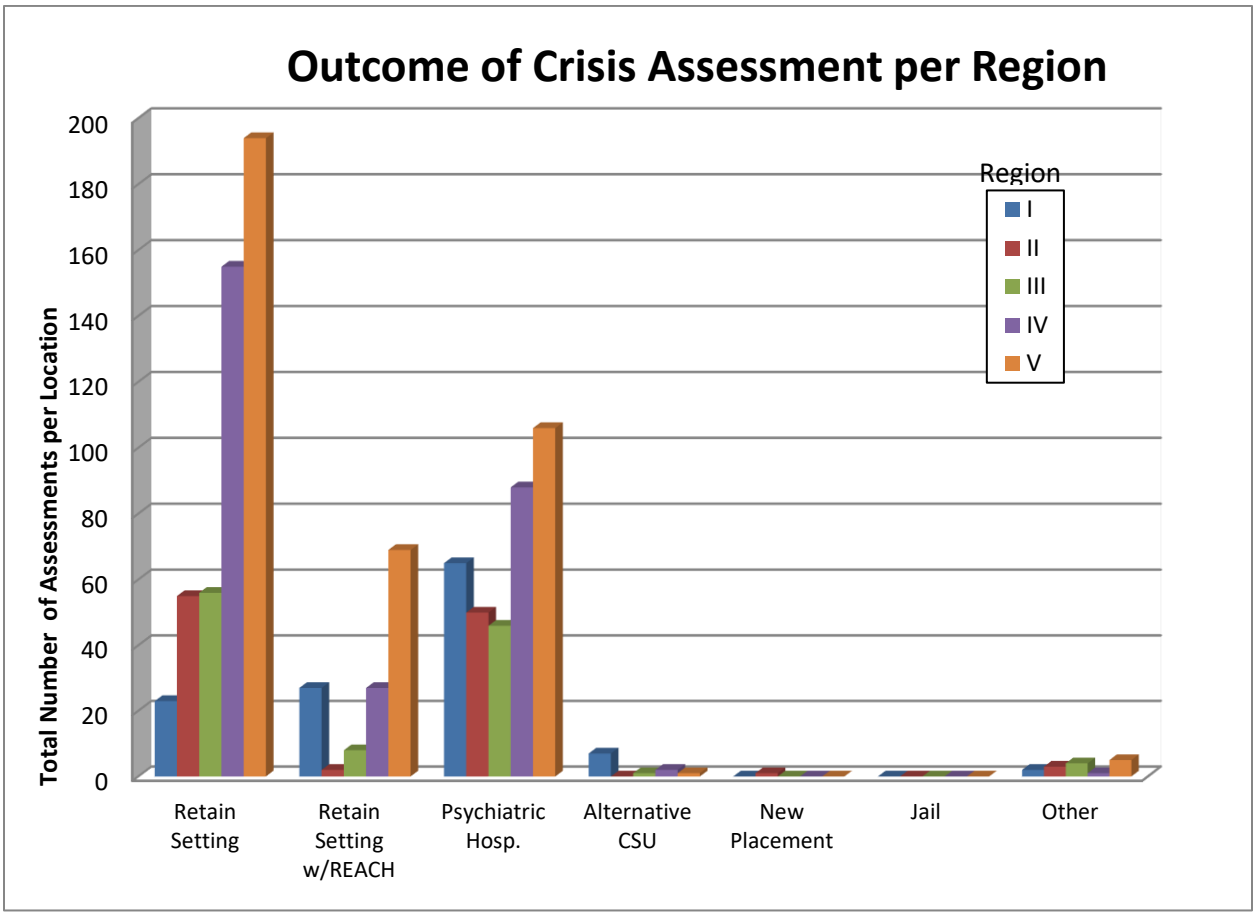
Since program inception, aggression has been the primary presenting challenge listed as the reason for the referral to REACH (56% in FY16, 51% in FY17, 50% in FY18, and 52% in FY19). The second-most listed presenting challenge in FY19 was suicidal ideation/behavior, with increased mental health symptoms listed as third, and family needs assistance listed fourth; this is overall congruent with the hierarchy of presenting problems in other fiscal years. Other noted presenting challenges making up the remaining referrals for FY19 include engagement in self-injurious behaviors, unsafe community behavior, and loss of functioning.

Crisis Assessment Outcomes

A primary goal of a comprehensive, statewide children's crisis system of care is to provide supports to children and their families such that the child may retain their home setting and avoid placement in a more restrictive setting, such as hospitalization or jail. The percentage of individuals who were able to retain their setting/retain their setting with REACH remained at 62% from FY18 to FY19, and the percentage of individuals hospitalized also remained the same at 36%. Again, these data are reflective of hospitalizations/diversions at the time of the immediate crisis, which is determined at the discretion of the emergency services pre-screening clinician. REACH additionally collects data on children that were hospitalized that were unknown to the program in comparison to children that have been actively receiving services from REACH, which is also useful to consider when examining hospitalizations. There is an overall decreasing trend in the percentage of children being hospitalized that are actively in services, and a corresponding increasing trend in children being hospitalized that are not actively receiving REACH services. Over the past three fiscal years, the percentage of

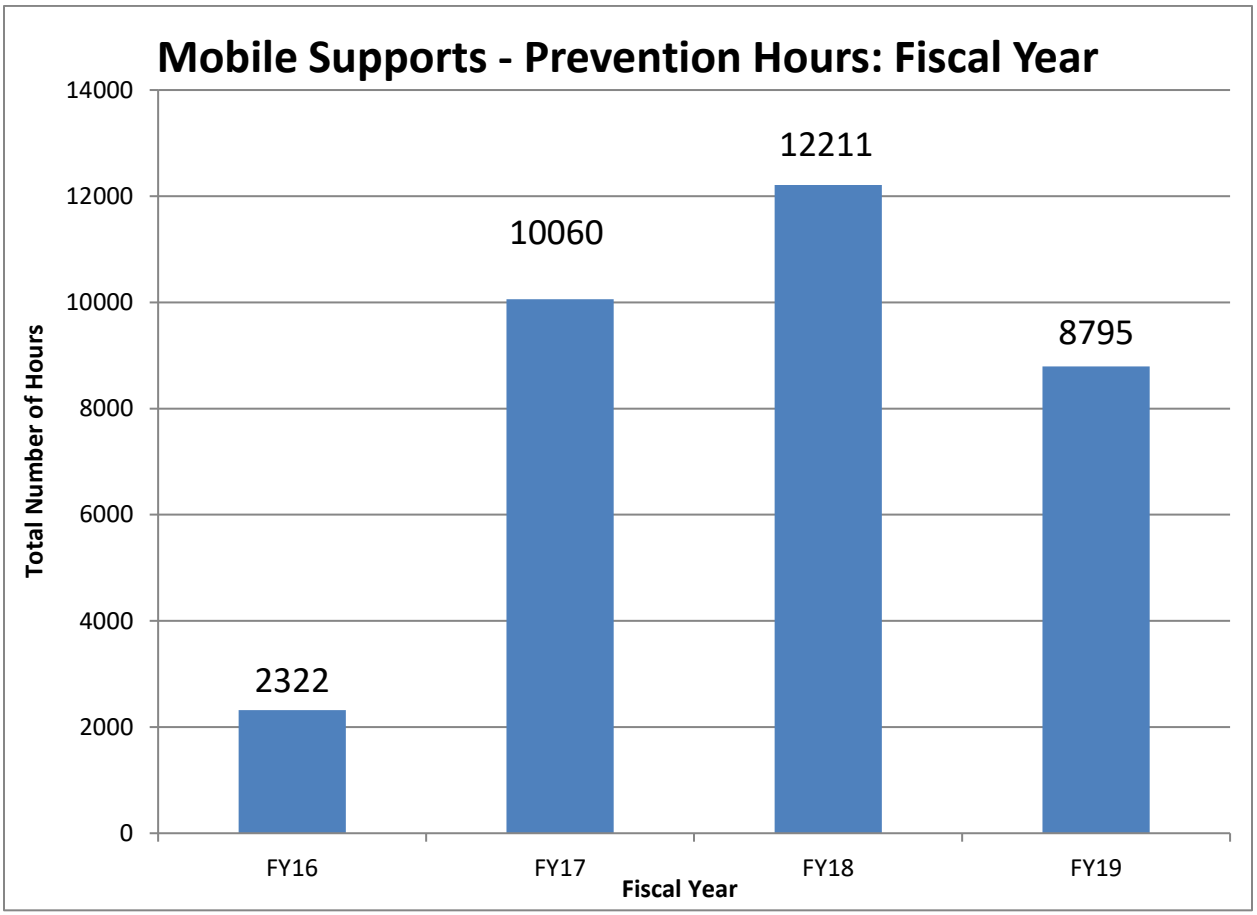
children hospitalized not known to the program has presented as follows: FY17 approximately 61%, FY18 approximately 65%, and FY19 approximately 71%. As it relates to children actively receiving REACH services, the percentages reflect a continued decreasing trend in hospitalizations, which are as follows: FY17 approximately 39%, FY18 approximately 35%, and FY19 approximately 29%. These data suggest the efficacy of REACH services to the child population; in essence, the data are indicative of when a child has actively participated in REACH services, he/she is much less likely to be hospitalized when compared to a child that has not accessed REACH services. Currently underway is the establishment of two crisis therapeutic homes (CTH) which will serve the northern (Regions I and II) and southern (Regions III, IV, and V) geographies of the state; it is anticipated that the child CTH in both geographies will be completed early in FY20. Additionally, a request for information process was completed in late FY19 to target out of home crisis prevention services for children. In FY20, it is anticipated that a formal request for proposal will occur with the hopes of procuring providers to deliver front-line, short-term out of home crisis prevention services which will serve as an additional option to mitigate the need for longer term out of home restrictive placements.



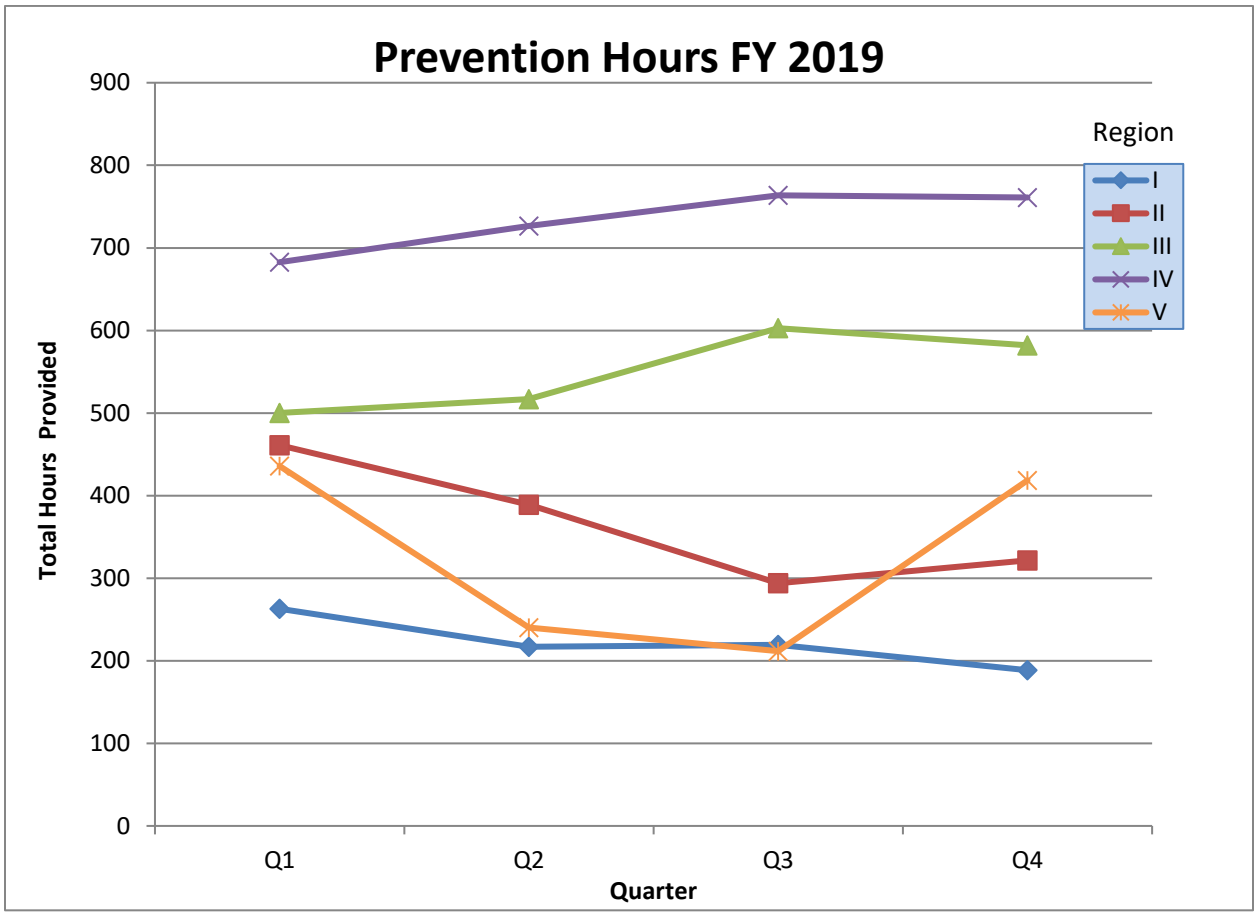


Mobile Crisis and Prevention

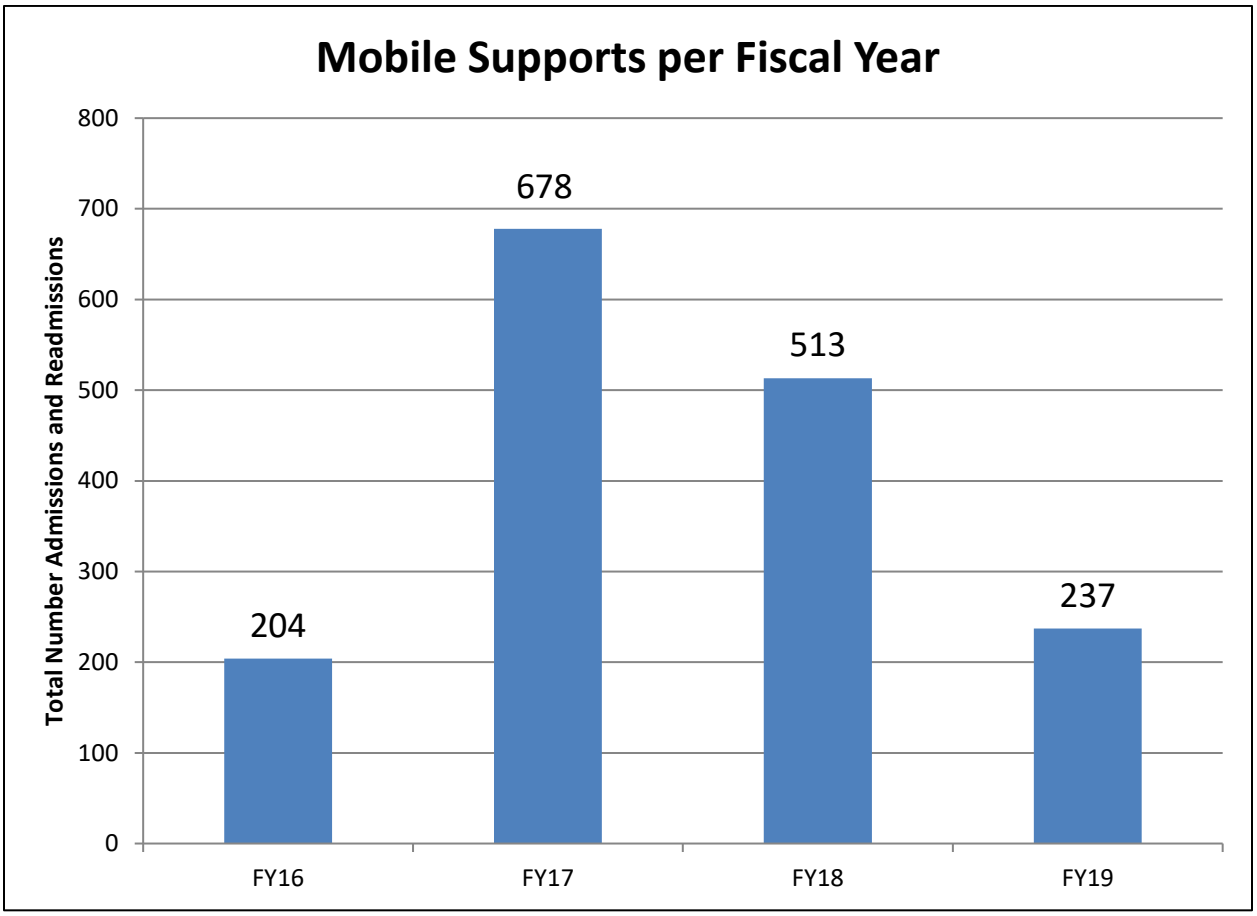
The following graphs indicate the number of prevention hours provided since inception of the Child REACH program. Prevention services can present in several different topographies; for example, these services may be inclusive of time spent on the phone with known clients to brainstorm coping strategies from their individualized Crisis Education and Prevention Plan, or could consist of time spent face to face with the individual and their family/provider when they are not actively in crisis as a means to continue to work on replacement/prosocial behaviors and/or other strategies that have been effective in keeping the individual out of crisis. As demonstrated in the display below, there has been a sharp decrease in the number of prevention hours provided between FY18 to FY19 (39% decrease in prevention hours provided). This may be reflective of a period of stabilization for many children supported by the program as there are an increasing percentage of children that are able to maintain a community setting when supported through REACH mobile supports. DBHDS will continue to examine this trend with the REACH programs to ensure that preventative services are being afforded to all that would continue to benefit from post-mobile supports, as well as to ensure measurement fidelity.

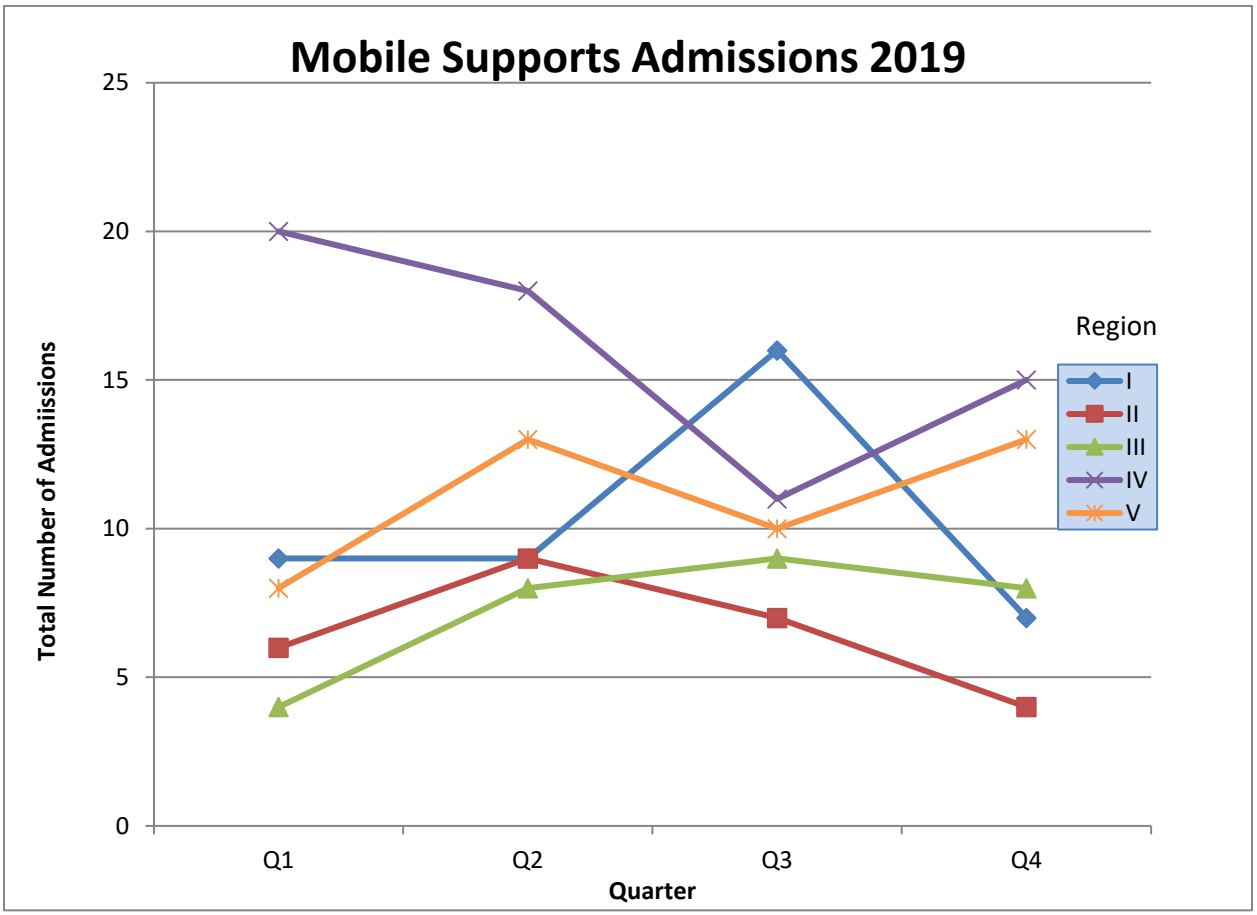


The graph below parses out prevention hours per program by quarter. Throughout the fiscal year Region IV provided more prevention hours than all other regions. Region III and Region IV demonstrate an overall increasing trend in prevention hours provided over the fiscal year, whereas Regions I and II demonstrate an overall decreasing trend in prevention hours provided. Region V's prevention hours decreased from Q1 through Q3 and then increased again in Q4 to come close to the number of hours provided in Q1.

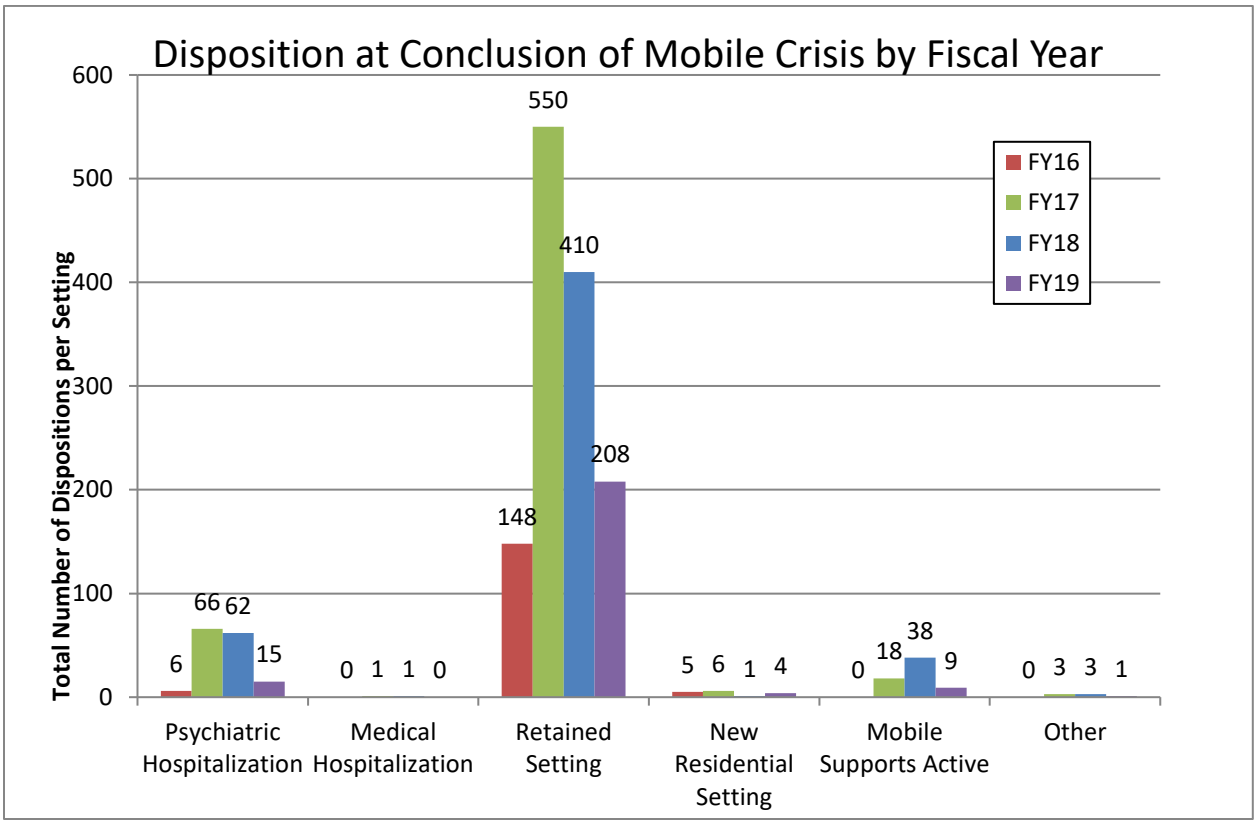


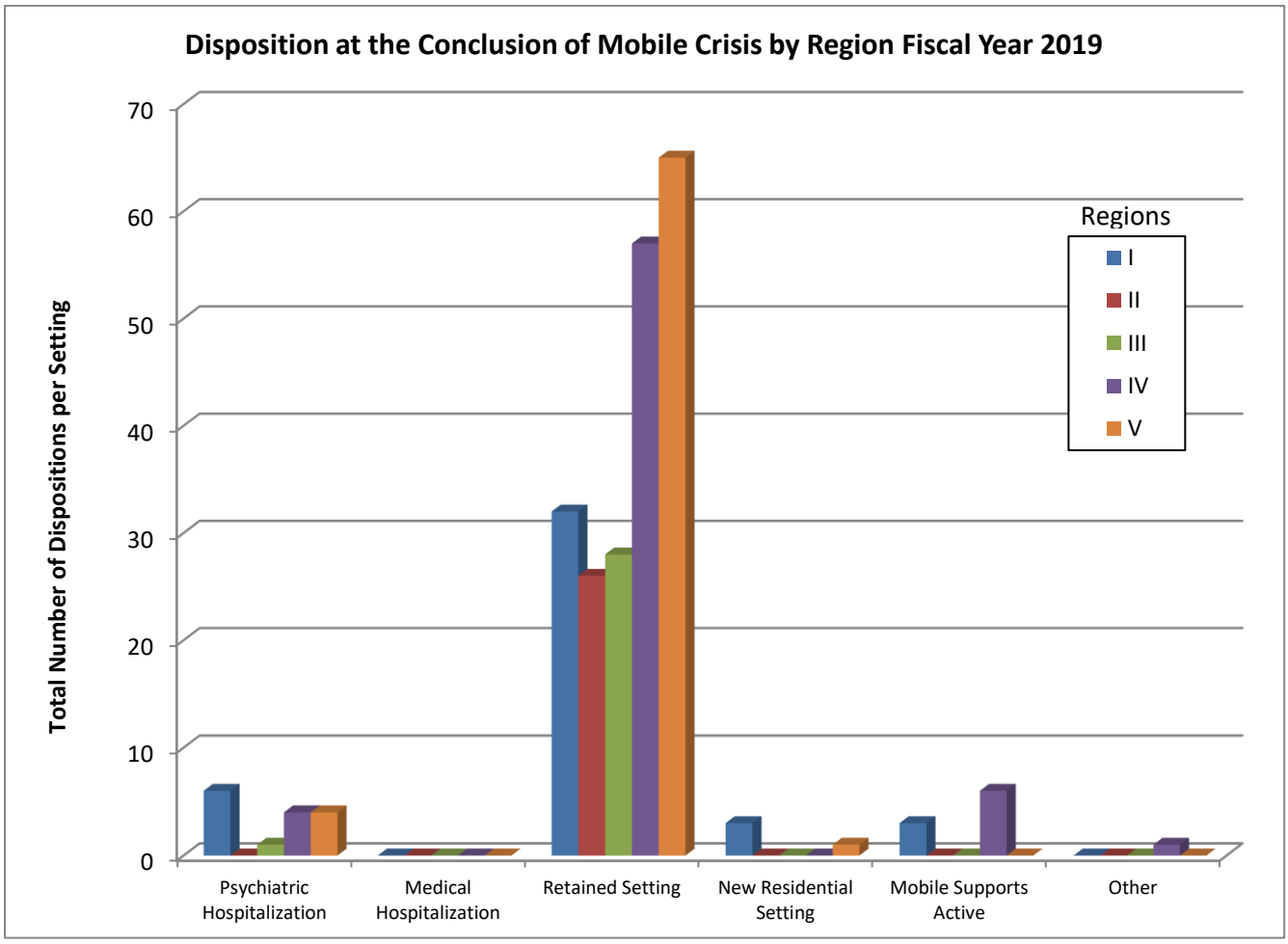
As illustrated in the charts below, the data provided by the programs indicate a decrease in the number of total admissions and readmissions to mobile supports from FY17 through FY19. As noted previously in this report, there was a shift in tracking mobile support admissions for Regions I and II in FY18, which may have led to an overestimation of the number of children enrolled in these services in previous fiscal years (e.g. children in "prevention" noted in mobile supports data for Region I, and children receiving mental health services and/or prevention services through the previous operator of Region II may have been included in mobile supports data). With those factors noted, the overall decreasing trend will continue to be examined in the upcoming fiscal year with all regions. It is important to note when considering mobile supports that these are separate from prevention services (as described above); mobile supports are community based crisis services that are instituted immediately following a crisis situation as a means to continue to stabilize the crisis and obviate out of home placement. Additionally, and as noted previously in this report, new data measures will be implemented in FY20 to more closely track and analyze prevention services provided for REACH consumers.


Mobile Supports per Fiscal Year
Total Number Admissions and Readmissions
800
700
600
500
400
300
200
100
0
204
678
513
237
FY16
FY17
FY18
FY19



The data illustrated on the next two pages indicates the regional programs are succeeding in their endeavors to support children in crisis such that they are able to remain in their homes or an alternative community residence. In FY19, approximately 94% of individuals served by mobile supports were able to retain their current placements or have a lateral move to another residential placement and avoid hospitalization; only 6% of children had a disposition of psychiatric hospitalization post mobile supports. This demonstrates a positive trend as it relates to the percentage of children that avoided hospitalization as a result of REACH mobile supports. In FY17, approximately 11% of children were psychiatrically hospitalized and in FY18 approximately 12% of children were psychiatrically hospitalized post mobile supports. Region by region, this trend is also clear for FY19 data. When examining dispositions at the conclusion of mobile supports by region, it is important to contrast the number of individuals who retained a community setting versus the number who were hospitalized, as opposed to comparing the number of dispositions from one region to another.


Disposition at Conclusion of Mobile Crisis by Fiscal Year
Total Number of Dispositions per Setting
600
500
400
300
200
100
0
FY16
FY17
FY18
FY19
6
66
62
15
0
1
1
0
148
550
410
208
5
6
1
4
0
18
38
9
0
3
3
1
Psychiatric Hospitalization
Medical Hospitalization
Retained Setting
New Residential Setting
Mobile Supports Active
Other



Conclusions

This report has summarized the work of the Child REACH programs over the course of the most recent fiscal year and drawn comparisons across the full three fiscal years' worth of data that are now available (FY17 through FY19). Similar to what was described in previous annual reports, the Child REACH programs have benefitted from the experiences of the Adult REACH programs and have learned and adapted based upon their own challenges and successes since the inception of the program in FY16.

The programs are becoming more integrated into and utilized as a resource in the communities which they serve; as evidence of this, the Child REACH programs trained 6,631 community partners in FY18 (FY17= 4,028 community partners trained, FY18=6795 community partners trained) on various topics related to the care and treatment of individuals with developmental disabilities and/or dual diagnoses (mental health disorders). It should be noted that all regional training data are duplicative of adult training data throughout the fiscal year, with the exception of that of Region I. The 6,631 community partners that received training from the Child REACH programs are in addition to and not inclusive of the individualized training provided to the individuals, care staff, families, and community partners who support children and adolescents with DD.

In addition to training provided directly by REACH, DBHDS in conjunction with the Department of Criminal Justice Services, the Virginia Board for People with Disabilities, and Niagara University continue to offer comprehensive training targeting disability awareness for law enforcement in Virginia. Trainings consist of both the originally offered broad "Disability Awareness for Law Enforcement" to more specific training content areas (e.g. Law Enforcement Response to Individuals with I/DD, Law Enforcement Response to Individuals with Brain Injury). This training series will continue to be provided in upcoming quarters through the partnership with DCJS, VBPD, and Niagara University. The REACH programs (both adult and child) in conjunction with DBHDS have hosted training opportunities this year in which regional and national experts in developmental disabilities, ethics, dual diagnoses, trauma informed care, and third wave behavioral therapy have offered continuing education to both REACH staff and the larger community as a whole. It is anticipated that such training partnerships to offer training from renowned experts will continue in the upcoming fiscal year.

DBHDS and the Child REACH programs continue to work toward the longstanding goal of offering out-of-home crisis stabilization services that parallel that of the Adult REACH programs' crisis therapeutic homes. At the time of this report, one home (Chester) has secured a certificate of occupancy and is awaiting licensing review; the other home (Culpeper) has a temporary certificate of occupancy and is awaiting several "punch list" items for completion with the builder before moving forward with submitting for a license. The home in Region II will serve children from both Regions I and Regions II, while the home in Region IV will serve Regions III, IV, and V. These homes may serve as a step-down from hospitalization for children who may need ongoing crisis prevention and stabilization services prior to fully integrating back into their communities. The efforts underway for these homes, which are anticipated to be open to guests early in FY20, are in addition to ongoing efforts by DBHDS to build community capacity with providers who are able to support the challenging mental health and/or behavioral needs of children with DD in the Commonwealth.

The Child REACH programs continue to improve in the quality and efficacy of service delivery as evidenced by strong outcomes data for children that are known to REACH and the correlation between the advent of community based crisis services and avoiding long term restrictive levels of care (e.g. hospitalization). Quarterly and annual quality reviews conducted during the fiscal year, in conjunction with quarterly data sets provided by each region, demonstrate that the programs continue to make progress toward the goal of a unified statewide crisis system of care for children.